Foot Care Associates of Texas
Dr Michael Wynn
23972 A Hwy 59 North Kingwood, TX 77339

Patient Name _____ Gender ◯ M ◯ F
First Middle Last

Address _____

City/St/Zip _____

FULL SOCIAL SECURITY IS REQUIRED TO FILE WITH INSURANCE IF WE DON'T HAVE YOU WILL BE LIABLE FOR FULL PAYMENT AT TIME OF SERVICES

SSN _____ Date of Birth _____/_____/_____
Email _____ Marital Status ◯ M ◯ S ◯ D ◯ W

Home Phone: _____ Work _____ Cell _____

Please circle preferred contact number.

Height _____ Weight _____lbs Shoe size _____

Primary language _____

Race ◯ American Indian/Alaskan Native ◯ Asian ◯ Hispanic or Latino
◯ Native Hawaiian or Other Pacific ◯ White ◯ Black or African American

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Patient Employer _____ Occupation _____

_____

Who can we notify about your appointments and release medical records to (other then yourself)?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Primary Physician _____ Date last Seen _____/_____/_____

Former Podiatrist _____

How did you hear about us? ◯ Insurance ◯ Internet ◯ Sign ◯ Phone book ◯ Patient ◯ other

If referred by a Doctor, whom may we thank? _____

Patient Name (print) _____ Signature _____

Parent or Authorized Representative (print) _____Date_____